GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ATYPICAL ANTIPSYCHOTICS PA SUMMARY

Preferred	Non-Preferred
Abilify tablets and oral solution (aripiprazole) Aripiprazole oral solution generic Geodon injection (ziprasidone)* Latuda (lurasidone) Olanzapine generic tablets, ODT Risperidone generic Quetiapine IR generic Ziprasidone generic	Abilify Discmelt (aripiprazole ODT) Abilify injection* (aripiprazole for short-acting injection) Abilify Maintena (aripiprazole long-acting injection) Aripiprazole tablets and ODT generic Aristada (aripiprazole lauroxil long-acting injection) Clozapine generic Clozapine ODT generic Fanapt (iloperidone) FazaClo (clozapine ODT) Invega (paliperidone) Invega Sustenna (paliperidone long-acting injection) Invega Trinza (paliperidone long-acting injection) Olanzapine short-acting injection generic Olanzapine/fluoxetine generic Paliperidone generic Rexulti (brexpiprazole) Risperdal Consta (risperidone long-acting injection) Saphris (asenapine) Seroquel XR (quetiapine extended-release) Symbyax (olanzapine/fluoxetine) Versacloz (clozapine oral suspension) Zyprexa injection* (olanzapine short-acting injection) Zyprexa Relprevv (olanzapine long-acting injection)

LENGTH OF AUTHORIZATION: 6 Months to 1 Year

NOTES:

- Prior authorization (PA) is not required for preferred generic products (olanzapine, quetiapine IR, risperidone, and ziprasidone), clozapine tablets (not ODT) or FazaClo for members that are within FDA-approved ages. For members between the ages of 5-16 using risperidone generic for pervasive developmental disorders (PDD)/autism irritability, PA is not required if the applicable ICD-10 code is provided on the prescription for the pharmacy to enter at the point-of-sale.
- Prior authorization is not required for brand short-acting injections (Abilify, Geodon, Zyprexa). Generic olanzapine short-acting injection requires PA with a written letter of medical necessity stating the reasons the brand Zyprexa short-acting injection is not appropriate for the member.
- If generic olanzapine/fluoxetine is approved, the PA will be issued for brand Symbyax. If generic clozapine ODT is approved, the PA will be entered for brand FazaClo. If paliperidone is approved, the PA will be entered for brand Invega.
- For all products requiring PA, a monitoring plan for safety and effectiveness is required.
- For **all** members younger than FDA-approved ages, PA must be requested by completing the Atypical Antipsychotic Prior Authorization Request Form and

faxing to OptumRx at 888-491-9742. Letter of medical necessity information should include diagnosis, medical and medication history, improvement in symptoms while on medication, monitoring plan and any other information or documentation supporting the use of the medication.

- The Atypical Antipsychotic PA Request Form is located at http://dch.georgia.gov/prior-authorization-process-and-criteria.
- For medications requiring PA, an extension of therapy may be requested for members that have been on therapy and are being tapered off of medication for discontinuation, for members that have been on therapy and whose PA is under review for age appropriateness, and for members that have been on therapy and are being referred to a psychiatrist and are awaiting an appointment.
- Physicians discharging a member from an inpatient facility stable and responding to a non-preferred agent should request PA as part of the patient's discharge planning.
- If an injectable medication is being administered in a physician's office or clinic then it must be billed through the DCH physician's injectable program and not the outpatient pharmacy program. Information regarding the physician's injectable program is located at www.mmis.georgia.gov/portal.

PA CRITERIA:

Clozapine Generic, Clozapine ODT generic, FazaClo, Olanzapine Generic (tablets, ODT), Risperidone Generic (tablets, ODT, oral solution), Quetiapine IR Generic and Ziprasidone Generic

- Prior authorization for members within FDA-approved ages is not required.
- Prior authorization for members outside of FDA-approved ages requires the Atypical Antipsychotic Prior Authorization Form to be completed.

Abilify Tablets and Aripiprazole Generic Tablets

- For members 10 years or older with a diagnoses of mixed or manic episodes associated with Bipolar Disorder, must demonstrate prior use *(*for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical justification as to why the preferred generic drugs are unacceptable therapy for the member.
- For members 13 years or older with a diagnosis of Schizophrenia/Schizoaffective Disorder, must demonstrate prior use (for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical justification as to why the preferred generic drugs are unacceptable therapy for the member.
- For members 6-17 years old with a diagnosis of Irritability Associated with Autism or PDD, must demonstrate prior use (for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical justification as to why the preferred generic drugs are unacceptable therapy for the member.
- For members 18 years or older with a diagnosis of Adjunctive Therapy for Major Depressive Disorder, must have had an inadequate response to at least

3 antidepressants (one of which must be an SSRI) and must use concurrently with an antidepressant.
- ❖ Approvable for members 6 to 17 years of age with a diagnosis of moderate to severe Tourette's syndrome resulting in impaired quality of life,
- ❖ In addition, for generic aripiprazole tablets, prescriber must also submit a letter of medical necessity stating the reasons brand Abilify is not appropriate for the member.

Clozapine ODT Generic
- ❖ Prescriber must submit a written letter of medical necessity stating the reasons brand FazaClo is not appropriate for the member.

Fanapt
- ❖ For members 18 years or older with a diagnosis of Schizophrenia/Schizoaffective Disorder, must demonstrate prior use (for at least a thirty day treatment period each) of at least 3 of the preferred generic drugs AND Abilify and Latuda within the last 12 months or physician must provide clinical justification as to why these medications are unacceptable therapy for the member.

Invega and Paliperidone Generic
- ❖ For members 18 years or older with a diagnosis of Schizophrenia/Schizoaffective Disorder, must demonstrate prior use (for at least a thirty day treatment period each) of at least 3 of the preferred generic drugs AND Abilify and Latuda within the last 12 months or physician must provide clinical justification as to why these medications are unacceptable therapy for the member. For members 12-17 years old, must demonstrate prior use (for at least a thirty day treatment period each) of at least 2 of the preferred generic drugs AND Abilify or physician must provide clinical justification as to why these medications are unacceptable therapy for the member.
- ❖ In addition, for generic paliperidone, prescriber must submit a written letter of medical necessity stating the reasons brand Invega is not appropriate for the member.

Invega Sustenna and Invega Trinza
- ❖ Members must be 18 years or older, have a diagnosis of Schizophrenia/Schizoaffective Disorder and be under treatment by or in consultation with a psychiatrist. In addition, documentation must be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has history of noncompliance or member is unable to swallow oral dosage forms.
- ❖ In addition, for Invega Trinza, member must have been established on Invega Sustenna for at least 4 months.

Latuda
- ❖ For members 18 years or older with a diagnosis of Schizophrenia/Schizoaffective Disorder, must demonstrate prior use (for at least a thirty day treatment period) of at least one of the preferred generic drugs within the last 12 months or physician must provide clinical

justification as to why the preferred generic drugs are unacceptable therapy for the member.

- For members 18 years of age or older with a diagnosis of depressive episodes associated with Bipolar Disorder, the member must have experienced ineffectiveness or must have an inability to take olanzapine (given concurrently or in combination with fluoxetine) or quetiapine.

Olanzapine Short-Acting Injection Generic

- A written letter of medical necessity is required stating the reasons the brand Zyprexa short-acting injection is not appropriate for the member.

Rexulti

- For members 18 years or older with a diagnosis of Schizophrenia/Schizoaffective Disorder, must demonstrate prior use (for at least a thirty day treatment period each) of at least 3 of the preferred generic drugs AND Abilify and Latuda within the last 12 months or physician must provide clinical justification as to why these medications are unacceptable therapy for the member.
- For members 18 years or older with a diagnosis of Adjunctive Therapy for Major Depressive Disorder, must have had an inadequate response to at least 3 antidepressants (one of which must be an SSRI) and must use concurrently with an antidepressant.

Risperdal Consta

- Members must be 18 years or older, have a diagnosis of Bipolar Disorder or Schizophrenia/Schizoaffective Disorder and be under treatment by or in consultation with a psychiatrist. In addition, documentation must be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has history of noncompliance or member is unable to swallow oral dosage forms.

Saphris

- For members 18 years or older with a diagnosis of mixed or manic episodes associated with Bipolar Disorder or Schizophrenia/Schizoaffective Disorder who have difficulty swallowing regular oral dosage forms or need monitoring by caregiver to ensure compliance, must demonstrate prior use (for at least a thirty day treatment period) of risperidone ODT generic or olanzapine ODT generic within the last 12 months or physician must provide clinical justification as to why the preferred ODT generic drugs are unacceptable therapy for the member. For members 18 years or older with a diagnosis of Bipolar Disorder or Schizophrenia/Schizoaffective Disorder who are able to swallow regular oral dosage forms, must demonstrate prior use (for at least a thirty day treatment period each) of at least 3 of the preferred generic drugs AND Abilify and Latuda within the last 12 months or physician must provide clinical justification as to why the these medications are unacceptable therapy for the member.
- For members 10-17 years of age with a diagnosis of mixed or manic episodes associated with Bipolar Disorder who have difficulty swallowing regular oral dosage forms or need monitoring by caregiver to ensure compliance, must demonstrate prior use (for at least a thirty day treatment period) of risperidone

ODT generic or olanzapine ODT generic within the last 12 months or physician must provide clinical justification as to why the preferred ODT generic drugs are unacceptable therapy for the member. For members 10-17 years of age with a diagnosis of mixed or manic episodes associated with Bipolar Disorder who are able to swallow regular oral dosage forms, must demonstrate prior use (for at least a thirty day treatment period each) of 2 of the following medications: risperidone, quetiapine or olanzapine within the last 12 months or physician must provide clinical justification as to why the these medications are unacceptable therapy for the member.

Seroquel XR

- For members 10 years or older with a diagnosis of manic or mixed episodes associated with Bipolar Disorder or for members 13 years of age or older with Schizophrenia/Schizoaffective Disorder, physician must submit documentation of allergies, contraindications, drug-drug interactions or a history of intolerable side effects to the ***inactive*** ingredients of quetiapine IR generic and must demonstrate prior use (for at least a thirty day treatment period each) of at least 2 of the other preferred generic drugs AND Abilify and Latuda (Latuda only applies to schizophrenia/schizoaffective disorder; not approved for manic or mixed episodes associated with Bipolar Disorder) within the last 12 months or physician must provide clinical justification as to why these medications are unacceptable therapy for the member.
- For members 18 years or older with a diagnosis of depressive episodes associated with Bipolar Disorder, physician must submit documentation of allergies, contraindications, drug-drug interactions or a history of intolerable side effects to the ***inactive*** ingredients of quetiapine IR generic AND must demonstrate ineffectiveness or an inability to take olanzapine (given concurrently or in combination with fluoxetine) or Latuda.
- For members 18 years or older with a diagnosis of Adjunctive Therapy for Major Depressive Disorder, must have had an inadequate response to at least 3 antidepressants (one of which must be an SSRI) and must use concurrently with an antidepressant.

Symbyax or Olanzapine/Fluoxetine Generic

- For members 18 years or older with a diagnosis of depressive episodes associated with Bipolar Disorder, an atypical antipsychotic and an antidepressant should be used as two separate products.
- For members 18 years or older with a diagnosis of Treatment-Resistant Major Depressive Disorder, prior use of at least 3 antidepressants (one of which must be an SSRI) is required.
- In addition, for generic olanzapine/fluoxetine, prescriber must submit a written letter of medical necessity stating the reasons brand Symbyax is not appropriate for the member.

Versacloz

- For members 18 years or older with a diagnosis of suicidal behavior associated with Schizophrenia/Schizoaffective disorder or treatment-resistant (refractory) Schizophrenia/Schizoaffective Disorder. Versacloz is approvable if administered in an NG tube or gastric tube. Otherwise, FazaClo dispersible

tablets are available and preferred over Versacloz for members with difficulty swallowing.

Zyprexa Relprevv

- Member must be 18 years or older, have a diagnosis of Schizophrenia/Schizoaffective Disorder and be under treatment by or in consultation with a psychiatrist. In addition, documentation should be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has a history of noncompliance or member is unable to swallow oral dosage forms.
- Must be administered in a REMS-certified outpatient facility.

Abilify/Aripiprazole Discmelt or Oral Solution

- The tablet oral dosage formulation should be used. Exceptions may be made for the following reason(s), if the member meets the criteria for the tablet oral dosage formulation: members with difficulty swallowing regular oral dosage forms, needs monitoring by caregiver to ensure compliance, or dose cannot be obtained with tablet formulation.
- Physicians requesting Abilify Discmelt must also provide clinical justification as to why preferred risperidone ODT generic or olanzapine ODT generic is unacceptable therapy for the member. Physicians requesting Abilify oral solution must also provide clinical justification as to why preferred risperidone oral solution is unacceptable therapy for the member.

Abilify Maintena and Aristada

- Member must be 18 years or older, have a diagnosis of Schizophrenia/Schizoaffective Disorder and be under treatment by or in consultation with a psychiatrist. In addition, documentation should be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has a history of noncompliance or member is unable to swallow oral dosage forms.

QLL CRITERIA:

- *For Clozapine, Olanzapine, Quetiapine IR, Rexulti, Risperidone, and Ziprasidone:* An authorization to exceed the QLL may be granted if the member's dose is being titrated due to initiation of therapy. The physician should submit faxed documentation of the proposed titration schedule.
- Additionally, for *olanzapine 20mg*, an authorization to exceed the QLL may be granted if physician submits faxed documentation of evidence of refractory schizophrenia/schizoaffective disorder and evidence that the member is being monitored for increases in weight, blood glucose, and lipid panel.
- For *low-dose quetiapine IR* (25mg at doses of 1 or 2 tablets per day or 50mg at dose of 1 tablet per day), the physician must submit a written letter of medical necessity. The member must also not be using another strength of quetiapine IR, an antidepressant, or an antipsychotic.

EXCEPTIONS:

- Physicians can request approval for members which have been started and stabilized on a non-preferred product for a reasonable period of time prior to

becoming Medicaid eligible or during hospitalization. It should be noted that use of samples does not constitute stabilization.

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process for members within FDA-approved ages may be initiated by **calling OptumRx at 1-866-525-5827**.
- ❖ The Prior Authorization process for members younger than FDA-approved ages must be initiated by completing the Atypical Antipsychotic Prior Authorization Request Form and **faxing to OptumRx at 1-888-491-9742**. The Atypical Antipsychotic Prior Authorization Request Form can be found at http://dch.georgia.gov/pharmacy > Prior Authorization Process and Criteria or directly at http://dch.georgia.gov/.prior-authorization-process-and-criterial.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to http://dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the Quantity Level Limits (QLL), please go to https://www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.